LEA: _____

School:_____

Plan of Care

Authorization for Rehabilitation Services

(Fully complete all sections.)

1. STUDENT NAME: _____ 2. DOB:_____

3. Medicaid#:

4. Physician: _____ 5. Physician's Phone:_____

6. Diagnosis: _____ ICD-9 Code:

7. Child's Functional Deficits: (Be specific.) _____

_____

_____

8. Summary of Previous Treatment: (Relative to goals.) _____

_____

_____

_____

9. Long Term Goals/Objectives: (include anticipated level of achievement and date of achievement, no more than 1 yr)

_____

_____

_____

_____

_____

10. Plan of Care

Discipline: ___ SLP ___PT ___ OT

Frequency:

Individual: ____ X/ _____

Group: ____ X/ _____

Individual and/or Group ____ X/ _____

Interventions, treatment, modalities: (Be specific.) _____

_____

Date Treatment Plan will be implemented: _____/_____/_____
Month/Day/Year

Med-8/ R2/05 (front)

11. Discharge:

Discharge Goal: _____

Discharge Plan (functional outcome):
___ Independent Home
___ Independent with assistive device(s)
___ Requires assistance
___ Requires supervision
___ Dependent

Discharge Disposition:
___ Home ___ Hospital
___ Other (specify)

_____

Anticipated Discharge Date: _____

12.

_____ _____
Signature of Therapist (Title) Date

Instructions for Plan of Care

1. Recipient's last and first name
2. Full date of birth (Month, day, year)
3. Complete Medicaid number (12 digits)
4. Name of physician
5. Telephone number of physician
6. Diagnosis related to rehabilitation therapy prescribed; include educational disabilities and ICD-9 code. What is this child's primary disability?
7. Enter functional deficits related to therapy prescribed; clinical signs and symptoms; deficits indicating therapeutic interventions.
8. Enter chronological picture of clinical course, summary of past treatment, and results of progress achieved during the most recent period of treatment. Thereafter, response to treatment is entered once a year when the plan of care is updated
9. 9. Enter long term goals/objectives, stated in functional outcomes (measurable), from the IEP. Describe the anticipated level of functional improvement together with time frames for anticipated improvement and/or goal achievement.

10. This section contains the physician's order and must identify the discipline, treatment, modality(s) and frequency. Enter therapeutic interventions to be provided by the therapist. Enter date treatment will begin relative to *this* plan - use month,date and year. (This is not when the therapy began during the school year, but when *this* plan begins.)
11. Describe the child's anticipated function. Check the most appropriate expected outcome and expected destination. Identify the anticipated discharge date. (Discharge refers to final termination of therapy and does not apply to the end of the school year.)
13. Provide signature and professional designation (title). Dates must be complete for month, day and year.